VOLUME VII
SECTION IV

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LONG-TERM CARE SERVICES

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CHAPTER D

1. INTRODUCTION

It is the responsibility of the social worker working with the adult and/or his or her representative to determine the most appropriate method of service delivery such as direct services, purchased services, or referral to another agency. This chapter identifies the primary services provided by local Adult Services programs and describes the local department's responsibilities in relation to other agencies.

2. HOME-BASED CARE SERVICES TO ADULTS

2.1 Home-Based Care Services Defined

2.1.1 Home-based care services consist of three components: companion, chore, and homemaker services.

2.1.2 Each local board shall provide for the delivery of at least one of these services to the extent that federal and/or state matching funds are made available. The local board shall determine which of the three services is mandated (*Code of Virginia*, § 63.2-1600).

2.1.3 The local board shall develop policy addressing all aspects of home-based care provided in the locality, including criteria for receiving home-based services, financial eligibility criteria, which home-based service(s) will be provided, and how an assessment will be conducted to determine the number of approved hours. The policy must be reviewed and approved by a Family Services Specialist prior to board approval.

2.2 Purpose of Home-Based Care Services

Home-based care services are used for the following purposes:

1) To provide protection to adults or prevent abuse, neglect, or exploitation;

2) To assist adults in attaining or retaining self-care, self-sufficiency, and independence; and

3) To prevent inappropriate institutionalization.

2.3 Eligibility for Home-Based Care Services

2.3.1 Eligible persons are adults who meet financial eligibility criteria contained in Volume VII, Section I, and local board policy, and who are assessed to need the service.

2.3.2 Home-based services shall not be provided for any adult in a residential care setting such as a nursing facility or assisted living

facility, or in a hospital. An adult is eligible to receive home-based services if one of the following conditions is met:

1) The home is owned in full or in part by the adult; or

2) The rent or mortgage and utilities, etc. are paid in the adult's name; or

3) The rent or mortgage, utilities, household expenses, etc., are shared between the adult and others; or

4) The adult lives in the home of a relative, friend, roommate, or other housing situation where the other person(s) living in the home is not a care provider, and the home is not a residential care setting or hospital.

2.3.3 Prioritizing Need for Home-Based Services/Waiting Lists

When funds are inadequate to maintain the level of services or to increase service delivery as needed, local departments shall develop criteria for prioritizing need and/or establish a waiting list. Waiting list criteria must be uniformly applied to all customers requesting the service. Waiting lists should be updated at least annually. Service by date of request is an acceptable means of administering a waiting list. Local departments may adopt additional criteria regarding the adult's living situation if diminished funding has reduced the availability of the service. Acceptable examples of additional criteria include providing the service only to individuals who live alone or who are at risk of institutionalization. Any other proposed policy must be sent to the appropriate family services specialist for approval prior to local board approval. Documentation of local board approval shall be submitted to the appropriate family services specialist.

2.3.4 Temporary Reduction or Termination of SSI

In cases where the Social Security Administration (SSA), the Department of Social Services, or the local department has made an error that requires a temporary reduction or temporary termination of the adult's SSI payment due to an overpayment, the adult **may** continue to be eligible for service as an SSI recipient. The case record must identify error(s) resulting in overpayment, who was responsible for the error(s), and what affect the error(s) had on the adult's SSI benefits.

2.4 Criteria for Companion Services

2.4.1 Definition

Companion services are performed by an individual or an agency provider who assists adults unable to care for themselves without assistance and where there is no one available to provide the needed services without cost. Companion services shall only be provided to an eligible adult who meets the eligibility requirements in Section 2.3 of this chapter. Activities include, but are not limited to:

1) Bathing
2) Dressing
3) Toileting
4) Eating/feeding
5) Transportation
6) Meal preparation
7) Shopping
8) Supervision
9) Light housekeeping
10) Companionship
11) Household/financial management

2.4.2 Provision of Companion Services

1) A parent, spouse, or other relative of an eligible adult may be approved as a companion provider if the written documentation shows that:

a) He or she is the most available and/or qualified person to provide the service;

b) He or she is unable or unwilling to provide these services free of charge; and

c) In the professional judgment of the worker, this would be the best plan of care for the adult.

2) A local department shall not establish policy that prohibits the utilization of a relative as a companion provider.

2.5 Criteria for Chore Services

2.5.1 Definition

Chore services are the performance of non-routine, heavy home maintenance for adults unable to perform such tasks. Chore services shall be provided for persons living in an independent situation who are responsible for maintenance of their residence and have no one available to provide this service without cost. Heavy home maintenance activities include but are not limited to:

1) Performing minor repair work on furniture and appliances in the home
2) Carrying coal, wood, and water
3) Chopping wood
4) Removing snow
5) Yard maintenance
6) Painting

2.5.2 Eligible Persons - Chore Services

To qualify for chore services, the following information must be documented in the case record:

1) The adult is living in an independent situation and is responsible for maintenance of his or her residence; and

2) The adult is unable to perform the necessary heavy home maintenance task(s).

2.5.3 Provision of Chore Services

Chore services shall not be purchased from a relative who is a member of the household; however, chore services may be purchased from a relative who is not a member of the household.

2.6 Criteria for Homemaker Services

2.6.1 Definition

Homemaker services are performed by an individual or an agency provider who provides instruction in (or, where appropriate, performs) activities to maintain a household. The activities include:

1) Personal care
2) Home management
3) Household maintenance

4) Nutrition
5) Consumer education
6) Hygiene education

2.6.2 Provision of Homemaker Services

1) Homemaker services may be provided directly by staff of the local department.

2) Services provided by all homemaker providers must be supervised and monitored by the social services worker or supervisor.

3) The adult receiving care must meet the requirements of Section 2.3 of this chapter.

2.7 Assessment Required for Home-Based Care Services

2.7.1 The local department shall use the Virginia Uniform Assessment Instrument (UAI) to assess the need for home-based services.

2.7.2 Each local department shall establish a procedure for conducting a home-based care assessment to determine the required number of service hours. The method used to determine the amount of services to be provided shall be approved by the local board and uniformly applied within each local department. Services should not be authorized prior to the date of assessed need. Any change in authorized hours shall be documented on an assessment form. The home-based care assessment shall be completed as needed, but at least annually for each adult receiving home-based services.

2.7.3 As part of the assessment, informal services (e.g., family, friends, community groups) and formal services shall be explored that could help meet the adult's needs. Home-based services may be used to complement informal and/or formal service providers, or they may be the only service provided to the adult.

2.7.4 An adult receiving home-based services may be assessed by the nursing facility preadmission screening team for nursing facility placement or community-based care when he or she is at risk of institutionalization. Although an adult may receive services from both programs in order to meet his or her needs, duplication of services must be avoided. Documentation in the service plan should demonstrate services provided by the local department and other providers. Care plans should be developed in coordination with other providers when possible.

2.8 Service Delivery – Home-Based Care Services

2.8.1 Each local department shall establish local board policy to specify the maximum number of hours of home-based service that may be provided per adult per week.

2.8.2 Each local social services department shall establish local board policy to specify the rate of pay for providers. Home-based providers must be paid at least minimum wage.

2.8.3 Social services are provided directly, by referral, or by purchase as required to ensure appropriate service delivery and resource utilization necessary for the implementation of the service plan.

2.8.4 The local department may develop a sliding-fee system for services. The local department fee systems must be approved by the appropriate family services specialist prior to local board approval.

2.8.5 When home-based services are contracted out to other agencies (i.e., not managed directly by the local department), the local department continues to be responsible for ensuring that the UAI and any needed reassessments are completed as well as ensuring compliance with other requirements noted in this section.

2.8.6 Home-based services shall be purchased from providers who are approved as meeting the standards established by the State Board of Social Services as set forth in 22 VAC 40-770-10 et seq. and Chapter E of Section IV of this manual.

2.8.7 If the adult's living situation does not meet minimal standards of safety (such as is required for the provision of Medicaid-funded personal care), the local department cannot deny services to the adult. However, the situation may preclude a provider from entering the home.

2.9 Receiving Home-Based Care Services and Medicaid Personal Care Services

2.9.1 Eligibility for one service does not necessarily preclude an adult's eligibility for another service.

2.9.2 The local department shall not deny or terminate home-based services solely because the adult is eligible for or receiving Medicaid personal care services. Before home-based services are terminated, the Medicaid personal care hours necessary to meet the adult's needs must be approved or recommended by the Medicaid personal care provider and/or the preadmission screening team; the Medicaid personal care program hours must be ready to be implemented. This does not prohibit the local department from terminating home-based

services if the combination of support systems and Medicaid personal care can meet the adult's assessed needs.

2.9.3 Home-based services cannot be denied based on the home-based services provider's level of training, education, or professional credentials as long as the provider can meet the needs of the adult and meets standards established in this policy.

2.9.4 If an adult is eligible for other services (such as Medicaid-funded personal care), but cannot afford the co-payment or chooses companion services in lieu of Medicaid-funded personal care, the local department cannot deny services to that adult if he or she meets eligibility requirements for the requested service(s).

2.10 The Local Department as the Adult's Fiscal Agent

See Chapter E for information on the relationship between department-approved providers of home-based services and the adult in care. Neither the state nor the local department of social services is the provider's employer.

3. ADULT DAY SERVICES

3.1 Definition – Adult Day Services

Adult day services is the purchase of day services from approved providers for a portion of a 24-hour day. Adult day services include personal supervision of the adult and promote social, physical, and emotional well-being through companionship, self-education, and leisure activities.

3.2 Eligible Persons - Adult Day Services

Eligible persons are those adults who meet financial eligibility criteria contained in Volume VII, Section I, and local board policy, and who fall within all of the following categories:

1) The adult has been assessed using the Virginia UAI as needing assistance with ADLs, IADLs, and/or supervision; and

2) The adult is in a family situation where the people normally responsible for his or her care are not available to provide such care; and

3) The adult does not live in an assisted living facility, nursing facility, hospital, or other public institution.

3.3 Purchase Components - Adult Day Services

The following are purchase components for adult day services:

1) Registration required by facilities when not a part of unit cost;

2) Transportation to and from center or home; and

3) Day services provided by a licensed or an approved provider.

3.4 Providers - Adult Day Services

Adult day services providers are either:

1) Licensed by the Department of Social Services, Division of Licensing Programs; or

2) Approved by the local department. The provider and home must meet the standards established by the State Board of Social Services. See also Chapter E of this section for standards.

3.5 Rates of Payment - Adult Day Services

Rates of payment for services shall be negotiated by the local department on an individual basis with each vendor according to policy governing purchase of services or by the rate-setting process for department-approved providers by the local board.

3.6 Service Requirements - Adult Day Services

The entire UAI must be completed to begin this service and must be updated at least annually.

4. ADULT FOSTER CARE

4.1 Definition – Adult Foster Care

Adult foster care is a locally optional program that provides room and board, supervision, and special services to an adult who has a physical or mental health need. The adult must be assessed prior to admission to the program using the Virginia UAI and determined to be incapable of independent living or unable to remain safely in his or her own home (*Code of Virginia*, § 63.2-1601). Adult foster care may be provided for up to three adults by any one provider. Care provided for more than three adults requires licensure by the Virginia Department of Social Services as an assisted living facility.

The provision of an adult foster care program must be approved by the local board of social services. Placements are made in homes approved by the

local department. There shall be local board policy addressing adult foster care when this option in chosen. Local departments are responsible for approving adult foster care homes in which their adult placements are made. If an adult foster care provider is approved by the local department, then the provider is bound by the department-approved provider standards and regulations (22 VAC 40-770-10 et seq.).

The local department may only approve adult foster care homes in which it will make placements. Local departments may not approve adult foster care homes for placements by other agencies that are not part of the VDSS system.

4.2 Eligible Persons/Payment Sources - Adult Foster Care

4.2.1 Local or Local-Only Funding Eligibility

Eligible persons are those adults who meet financial eligibility criteria contained in Volume VII, Section I, and local board policy, and who are assessed to need the service.

4.2.2 Auxiliary Grants Eligibility

Eligible persons are those adults who meet the criteria for a monetary payment under the Auxiliary Grant (AG) Program (to be determined by the eligibility worker), and local board policy, and who are assessed to need the service.

4.2.3. Private Pay

Eligible persons are those adults who are incapable of independent living or unable to remain safely in their own home and have the resources to pay for a private placement in an approved adult foster care home. This option should be outlined in the agency's adult foster care local policy and approved by the local board of social services.

4.3 Services Provided by the Local Department - Adult Foster Care

Services that the local department shall provide as part of adult foster care are:

4.3.1 Recruitment, screening, and approval of the adult foster homes (refer to Volume VII, Section IV, Chapter E).

The intent of the adult foster care program is to keep the adult in his or her own community. The recruitment of adult foster care homes and the placement of adults are limited to bordering city/county jurisdictions, so long as the adult's specified needs can be met in the adult foster care home.

Prior to the recruitment and approval of adult foster care homes and the placement of an adult in another bordering jurisdiction, there shall be a written agreement between the placing and receiving jurisdictions. The appropriate Family Services Specialist shall receive a copy of the agreement prior to the placement. A sample interagency agreement is found in Appendix B of this chapter.

4.3.2 Assessment Using the Virginia UAI

The entire UAI must be completed for each applicant to adult foster care prior to the beginning of the service and must be updated at least annually. Each applicant for adult foster care is assessed to determine his or her need for adult foster care and special services. The worker must evaluate the adult's ability to perform activities of daily living, instrumental activities of daily living, manage medications, the adult's behavior pattern and orientation, and assess the availability of the informal support systems (i.e., family, friends, neighbors, community groups, etc.) to assist in meeting the adult's needs. Based on the results of the UAI assessment, the local department will determine if the adult's needs:

1) Can be met by independent living with supportive services;

2) Can be met by a placement in adult foster care; or

3) Require a higher level of care such as an assisted living facility or nursing facility placement.

4.3.3 Assistance with Placement

Assistance with placement arrangements is provided to match the adult to an approved provider. This is based on:

1) The adult's assessed need(s);

2) Compatibility with the provider and other residents of the adult foster care home; and

3) Ability of the adult foster care provider to provide any needed special services as identified by the assessment.

The local department shall arrange for services that may be needed by the adult from other community agencies prior to the placement of the adult in adult foster care or as the need arises.

4.3.4 Monitoring

The local department shall monitor the services that are provided to the adult and the provider for ongoing compliance. Local department staff shall visit the home of the provider as often as necessary, but at least every six months. The purpose of the monitoring visit is to determine the provider's compliance with applicable requirements and the progress and well-being of the adult.

The local department will reapprove the provider prior to the end of the 24-month approval period if the provider continues to meet requirements. The local department shall determine and document that the provider is qualified to provide the special services required by the adult. For example, if the physician has instructed the provider on the correct procedure for dressing changes or medication management, the provider is able to and does provide the service, and this is documented.

4.3.5 Ongoing Contact

The placing local department will maintain contact with the adult in care and the provider as required by Adult Services policy. The placing department maintains responsibility for the provision of direct services, case management, ongoing supervision of the adult, and monitoring of services provided in the adult foster care home. The case shall remain open as long as services are provided, and the service plan must be evaluated and updated as required by case management policy (see Volume VII, Section IV, Chapter C, and Section I, Chapter B).

4.3.6 Auxiliary Grant Local or Local-Only Payments

The placing local department is responsible for the Auxiliary Grant payment or the local or local-only payment for the provision of services in public-funded adult foster care.

4.4 Medical Examination - Adult Foster Care

Each adult placed in the foster care home shall submit a medical statement obtained from a licensed physician or a local health department which shall contain the following information:

1) Date of last physical examination (must have been within 60 days of placement in adult foster care);

2) Diagnoses of significant problems;

3) Documentation that the adult is believed to be free from tuberculosis in a communicable form; and

4) Recommendation for care including medication, diet, and therapy(ies).

4.5 Purchased Services - Adult Foster Care

The following services are included in the rate paid to the adult foster care provider for a publicly funded adult in care:

4.5.1 Room and Board

1) Provision of a furnished room in a home that meets applicable zoning, building, and fire safety codes.
2) Housekeeping services based on the needs of the resident.
3) Meals and snacks, including extra portions and special diets.
4) Clean bed linens and towels as needed and at least weekly.

4.5.2 Maintenance and Care

1) Assistance with personal hygiene including bathing, dressing, oral hygiene, hair grooming and shampooing, care of clothing, shaving, care of toenails and fingernails, arranging for haircuts as needed, care of needs associated with menstruation or occasional bladder or bowel incontinence.
2) Medication monitoring.
3) Provision of generic personal toiletries including soap and toilet paper.
4) Assistance with the following: care of personal possessions; care of personal funds if requested by the adult and the home's policy permits it; use of telephone; arranging transportation; obtaining necessary personal items and clothing; making and keeping appointments; and correspondence.
5) Securing health care and transportation when needed for medical treatment.
6) Providing social and recreational activities as required by licensing regulations.
7) General supervision for safety.

4.6 Auxiliary Grants (AG) - Adult Foster Care

4.6.1 Maximum Rate to Be Paid to Adult Foster Care Providers

For all adults eligible for an AG payment and approved for adult foster care, the adult shall pay to the provider a rate not to exceed the maximum rate established for adult foster care. The local department shall not use local or local-only payments to reimburse the provider more than the maximum AG rate.

The adult foster care home may not request or require the receipt of any money, gift, donation, or other consideration from or on behalf of

an adult as a condition of admission or continued stay. AG checks must be provided directly to the resident or his or her responsible party who then pays the provider. The foster care home is required to provide each resident a monthly statement or itemized receipt of the account. Unless a guardian or conservator has been appointed by the court, the resident is free to manage his or her personal finances.

4.6.2 Room, Board, Supervision, and Special Services

An agreement stating the amount to be paid by the adult shall be reduced to writing and fully explained to the adult. The social worker, adult foster care provider, and the adult in care shall sign this agreement. A sample agreement for adult foster care is found in Appendix A of this chapter.

Any modifications in the amount to be paid shall be indicated on the signed agreement and initialed and dated by the social worker, the adult foster care provider, and the adult in care. Appropriate notification to the eligibility worker shall be made.

The adult in care shall be allowed to retain a portion of his income/AG for personal use money. The amount retained shall not be less than what is allowable under the AG program.

4.6.3 Determining Eligibility of an Adult Foster Care Recipient for an Auxiliary Grant Payment

An adult must be determined eligible to receive an AG payment in accordance with AG eligibility policy.

For an adult to be eligible for an AG for adult foster care, the following shall occur:

1) Both the social worker and the eligibility worker must determine the adult's eligibility. Whoever has contact with the adult first shall refer the adult to the other.

2) The service and financial eligibility determination processes shall occur simultaneously when possible. The social worker shall assess the adult's needs and arrange for the potential placement. The eligibility worker shall determine financial eligibility and shall notify the social worker of the adult's eligibility.

3) Upon notification that the adult is eligible for an AG, the social worker shall assist with the placement. The social worker shall provide verification to the eligibility worker of the placement and the rate to be paid to the provider. The eligibility worker shall approve the case and determine the amount of the AG. Local

departments must ensure that there is in-house coordination of information between the social worker and the eligibility worker.

4.7 Non-Public Pay Residents – Adult Foster Care

Adults who have their own resources may be placed in approved adult foster homes when they meet the same assessment criteria as local or local-only funded AG residents, and this action has been approved by the local department of social services board.

4.8 Coordination with Local Community Services Boards – Adult Foster Care

Local departments of social services are encouraged to coordinate with community services boards (CSBs) in the provision of adult foster care to adults with mental illness and/or mental retardation. Local departments shall enter into an administrative support agreement with the local CSB concerning adult foster care. This agreement should specify which agency will be responsible for assessment, monitoring of services, placement, and discharge services provided to an adult with mental illness and/or mental retardation in the adult foster care home.

The local department of social services is responsible to approve the adult foster care home and follow the requirements of this chapter when the adult's placement is assessed and funded by the local department of social services.

The local department of social services has no responsibility for approving adult foster care homes when placement and services are provided and funded by the CSB or any other agency.

5. PURCHASED SERVICES FOR ADULTS

Other purchased services which may benefit an adult are:

1) Any services needed by an Adult Protective Services customer
2) Counseling and treatment
3) Drug treatment
4) Education and training
5) Employment
6) Family and personal adjustment counseling
7) Family planning
8) Health-related services
9) Housing
10) Legal services
11) Nutrition-related services
12) Services to specified persons with disabilities
13) Socialization/recreation services

14) Transportation

6. ASSISTED LIVING FACILITY (ALF) ASSESSMENT

6.1 Introduction to ALF Assessment

The following is a brief overview of the assessment process for ALF residents. Please refer to the *Assisted Living Facility Assessment Manual* for complete information.

For information on assessment of private pay residents, see the *User's Manual: Virginia Uniform Assessment Instrument for Private Pay Residents of Assisted Living Facilities.*

See Chapter A of this section for information on obtaining these manuals.

6.2 Definition of ALFs

ALFs are licensed by the VDSS Division of Licensing Programs to provide care and maintenance to four or more adults. ALF placement is appropriate when the adult is assessed to need assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), administration of medication and/or supervision due to behavioral problems, but do not require the level of care provided in a nursing facility.

6.3 Persons to Be Assessed in ALFs

All residents of and applicants to ALFs, regardless of payment status or anticipated length of stay, must be assessed using the Virginia UAI to determine the need for residential or assisted living. Except in the case of a documented emergency, all individuals must be assessed prior to the ALF placement.

6.4 Assessors for Public Pay Individuals in ALFs

1) Local departments of social services
2) Area agencies on aging
3) Local departments of health
4) Community services boards
5) Centers for independent living
6) State facility staff of the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS)
7) Designated staff of the Department of Corrections.
8) Entities contracting with DMAS to perform nursing home preadmission screening (NHPAS) or to complete the UAI for a home- and community-based waiver program, including an independent physician contracting with DMAS to complete the UAI for residents of ALFs, or any hospital that has contracted with DMAS to perform NHPAS. An

independent physician is a physician chosen by the ALF resident and who has no financial interest in the ALF, directly or indirectly, as an owner, officer, or employee or as an independent contractor with the residence.

By statute, the local department is the assessor of last resort if there is no other assessor willing or able to perform the assessment or reassessment.

6.5 Assessors for Private Pay Individuals in ALFs

Unless a private pay (i.e., non-AG) individual requests that an assessment be completed by a public assessor, qualified staff of the ALF or an independent private physician may complete the UAI for private pay individuals. Qualified staff of the ALF is an employee with documented training in the completion of the UAI. The administrator or the administrator's designated representative must approve and sign the completed assessment.

6.6 Assessment and Determination of Services to Be Provided in ALFs

A training manual entitled *User's Manual: Virginia Uniform Assessment Instrument* provides thorough instructions regarding completion of the assessment. Information gathered on the UAI will allow the assessor to determine whether the individual meets the level of care criteria for ALF placement. An individual must meet these criteria to be considered for public-funded ALF placement.

The UAI is comprised of a short assessment and a full assessment. The short assessment (Part A or pages 1-4) plus an assessment of the individual's medication management ("How do you take your medicine?" question on page 5 of the UAI) and behavior ("Behavior Pattern" section on page 8 of the UAI) is designed to briefly assess the individual's need for services and to determine if a full assessment (Parts A+B or entire UAI) is needed. The assessment focuses on the individual's ability to function while documenting functional dependencies and other needs. Emphasis must be on assessing the total individual to determine activities he or she is able to safely perform in his or her usual environment.

For public pay individuals, the short assessment must be completed. (Note: DMAS will only reimburse the assessor at the short-form rate if that is all that is needed even if the full assessment is completed.) If, upon completing the short assessment, it is noted that the individual is rated dependent in two or more ADLs or is rated dependent in behavior pattern, then a full assessment is completed. DMAS will monitor assessments to ensure that the appropriate version (i.e., short vs. full) is completed.

6.7 When to Complete a UAI for ALF Residents

6.7.1 The UAI must be completed or updated within 90 days prior to the date of admission to the ALF. No one can be admitted to an ALF without having been assessed prior to admission except in the case of a documented emergency placement.

6.7.2 An assessment using either the short-form or complete UAI, as appropriate, must be completed or updated at least once every 12 months on all ALF residents.

6.7.3 The UAI must be completed or updated as needed whenever there is a change in the resident's condition that appears to warrant a change in the resident's approved level of care.

6.8 Criteria for Placement in an ALF

6.8.1 Criteria for Residential Living

Individuals meet the criteria for residential living as documented on the UAI when at least one of the following describes their functional capacity:

1) Rated dependent in only one of seven ADLs (i.e., bathing, dressing, toileting, transferring, bowel function, bladder function, and eating/feeding) (page 4 of UAI).

2) Rated dependent in one or more of four selected IADLs (i.e., meal preparation, housekeeping, laundry, and money management) (page 4 of UAI).

3) Rated dependent in medication administration (page 5 of UAI).

6.8.2 Criteria for Assisted Living

Individuals meet the criteria for assisted living as documented on the UAI when at least one of the following describes their functional capacity:

1) Rated dependent in two or more of seven ADLs (page 4 of UAI).

2) Rated dependent in behavior pattern (i.e., abusive, aggressive, or disruptive) (page 8 of UAI).

6.8.3 Prohibited Conditions

Assessors must also determine that individuals do not have any of the prohibited conditions listed below before authorizing placement in an ALF. If any of these conditions are present, the assessor must document that they are present on the UAI and the AG recipient or

applicant is not eligible for ALF placement. Please refer to the *Assisted Living Facilities Assessment Manual* for more specific information on prohibited conditions.

State law prohibits admission or retention of individuals in an ALF when they have any of the following conditions or care needs:

1) Ventilator dependency.

2) Dermal ulcers stage III and IV except those stage III ulcers which are determined by an independent physician to be healing and care is provided by a licensed health care professional under a physician's treatment plan.

3) Intravenous therapy or injection directly into the vein except for intermittent intravenous therapy managed by a health care professional licensed in Virginia.

4) Airborne infectious disease in a communicable state that requires isolation of the individual or requires special precautions by the caretaker to prevent transmission of the disease.

5) Psychotropic medications without appropriate diagnosis and treatment plans.

6) Nasogastric tubes.

7) Gastric tubes except when the individual is capable of independently feeding himself or herself and caring for the tube.

8) Individuals presenting an imminent physical threat or danger to self or others.

9) Individuals requiring continuous licensed nursing care (seven days a week, twenty-four hours a day).

10) Individuals whose physician certifies that placement is no longer appropriate.

11) Unless the individual's independent physician determines otherwise, individuals who require maximum physical assistance as documented by the UAI and meet Medicaid nursing facility level of care criteria as defined in the State Plan for Medical Assistance.

12) Individuals whose health care needs cannot be met in the specific assisted living facility as determined by the ALF.

Private Pay Individuals Only/Exceptions to the above: At the request of the private pay individual, care for the conditions or care needs specified in (3) and (7) above may be provided to a individual in an ALF by a physician licensed in Virginia, a nurse licensed in Virginia under a physician’s treatment plan, or by a home care organization licensed in Virginia when the resident’s independent physician

determines that such care is appropriate for the resident. These exceptions do not apply to AG recipients. When care for a resident's special medical needs is provided by licensed staff of a home care agency, the ALF staff may receive training from the home care agency staff in appropriate treatment monitoring techniques regarding safety precautions and actions to take in case of emergency.

6.8.4 Intensive Assisted Living

Prior to March 17, 2000, there were two levels of assisted living care for payment purposes in ALFs (regular assisted living and intensive assisted living (IAL). The Centers for Medicare and Medicaid did not renew Virginia's IAL Waiver. On and after March 17, 2000, the IAL Waiver is no longer available as a Medicaid-funded alternative to nursing facility placement for new applicants. There are now only two levels of care: residential care and assisted living. Only those residents who were assessed at the IAL level of care on or before March 17, 2000, are eligible for the IAL reimbursement add-on.

Please see Broadcast #787 and Chapter VI of the *Assisted Living Facility Assessment Manual* for more information.

6.9 Possible Results from an ALF Assessment

1) A recommendation for ALF care;

2) Referral to a Nursing Facility Preadmission Screening Team to determine if the individual is appropriate for Medicaid-funded community-based care or nursing facility care;

3) Referrals to other community resources (non-Medicaid-funded) such as home-based care services, health services, adult day care centers, home-delivered meals, etc.; or

4) Referral for services not required.

6.10 Service Reporting for ALF Assessments

Cases should be opened following all usual adult services assessment and case management procedures. Case typing will depend upon the adult's situation at the time of the initial assessment. For cases needing ALF placement services, only the assessment requirements for completing the designated sections of the UAI must be followed. Once placement has been made and the case management agency has been designated, if applicable, the case may be closed. If the local department chooses to keep it open, the worker must comply with the quarterly/90-day contact requirement for open cases.

For case management, the case type would normally be **case type 86**. However, depending on the intensity of the needed case management services, **case type 82** may be appropriate for Medicaid-funded ALF targeted assessment.

Case type 74 is used in all cases where the resident has been a victim of abuse, neglect, or exploitation, or is at risk of abuse, neglect, or exploitation, and all APS procedures found in Volume VII, Section IV, Chapter B, of this manual must be followed if the individual is receiving protective services.

7. NURSING FACILITY PREADMISSION SCREENING

Individuals who are Medicaid eligible or will be Medicaid eligible within 180 days of placement and who are seeking Medicaid coverage for nursing facility care must be screened to determine their need for the service (*Code of Virginia*, § 32.1-330). See the *Virginia Medicaid Nursing Home Preadmission Screening Manual* for details on policies and procedures.

7.1 Community-Based Preadmission Screening Committee Responsibilities

7.1.1 Composition of the Committee

The committee must consist of a physician, a nurse, and a social worker who are employees of either the local department of health or local department of social services.

7.1.2 Responsibilities and Procedures

1) The committee determines:

a) If the adult meets nursing facility criteria upon completion of the UAI;

b) If the adult has a condition of mental illness, mental retardation, or a related condition, the committee must determine whether an additional screening for active treatment needs is necessary; and

c) If the care needs can best be provided in a nursing facility or in the community.

2) The social worker and/or the nurse on the committee must collaborate with the adult and the adult's family to identify resources to meet the adult's needs. All community-based services are to be considered.

3) The committee must notify the adult by letter of its decision to approve or deny the requested services.

7.2 Local Department of Social Services Responsibilities

7.2.1 Local departments have screening responsibilities for adults who:

1) Are residing in the community and desire a preadmission screening;

2) Receive out-of-state personal care or nursing facility services and move in-state needing personal care (the locality where the adult will reside is responsible for screening);

3) Are being paroled or otherwise released from a correctional facility and need a determination of Medicaid eligibility for placement in a nursing facility. Local departments are to accept these Medicaid applications even though the individual may be an inmate in a public institution at the time of application. The purpose of these applications is to determine eligibility for the individual at the time of release from prison. The parole officer will complete the Medicaid application and, if needed, the Medicaid History and Disability Report, and will send the application to the locality of residence prior to the inmate's incarceration. Preadmission screening will be completed by the local department of Health or local department of social services. Applications are subject to regular processing time frames.

7.2.2 Local departments *do not* have nursing facility preadmission screening responsibilities for persons who are:

1) In acute-care hospitals;

Adults seeking nursing facility preadmission screening when in an acute-care hospital should be referred to the hospital-based preadmission screening committee for screening. For adults being discharged from military or Veterans' Administration hospitals, refer to the *Medicaid Nursing Home Preadmission Screening Manual*.

2) Discharged from state mental health/mental retardation/substance abuse facilities;

Adults seeking nursing facility preadmission screening prior to discharge from a state mental health/mental retardation/substance abuse facility should be referred to DMAS for screening.

3) Transferred between nursing facilities within the state;

Adults transferred between nursing facilities within the state are not required to be screened by local screening committees. The nursing facility from which the individual is transferring sends a copy of all screening material to the receiving facility; the receiving facility initiates appropriate documentation for admission certification purposes.

4) Transferred from out-of-state nursing facilities entering in-state nursing facilities;

Direct transfers from an out-of-state nursing facility should be referred to the receiving nursing facility.

5) Currently receiving Medicaid-funded community-based care waivers; or

The local preadmission screening team is not responsible for screenings for individuals who are in either the Elderly and Disabled Waiver or the Consumer-Directed Personal Attendant Services Waiver and who are transferring to a nursing facility.

6) Currently receiving nursing facility services and transferred to a Medicaid-funded community-based waiver.

The local preadmission screening team is not responsible to screen individuals who currently are in a nursing facility and are transferring to a Medicaid-funded community-based waiver program.

7.3 Procedures for Adults Residing in the Community

7.3.1 Adults or their representatives should be referred to the local health department and/or social services department for screening in the jurisdiction in which the adult is living at the time of application.

7.3.2 If the adult is not already Medicaid-eligible, the adult should also be referred to the local social services department so that eligibility for Medicaid can be determined. Screening may occur either before or after determination of financial eligibility for Medicaid. DMAS will reimburse for screenings of individuals who are currently financially Medicaid-eligible or are expected to be financially eligible within 180 days of receipt of nursing facility care.

7.3.3 Decisions of the screening committees may be appealed. If an adult wishes to appeal, the adult must submit a written request within 30 days of the committee's action. The request must be sent to the

Recipient Appeals Unit, Virginia Department of Medical Assistance Services, 600 East Broad Street, Richmond, Virginia 23219.

8. SERVICES AVAILABLE TO CUSTOMERS OF THE DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES (DMHMRSAS)

8.1 Case Management

The local DMHMRSAS community services board (CSB) shall be contacted for information regarding the availability of case management services in the locality that it serves. Case management services provided by DMHMRSAS include assessing the need for services, planning for service delivery, linking the adult to the needed services, and monitoring the provision of services to the adult. Local departments may participate in the case management process.

8.2 Case Review by a Prescription Team

The local DMHMRSAS CSB should be contacted for information regarding the specific activities and services of the local DMHMRSAS board's prescription team.

The local social services department is identified in the *Code of Virginia* as a member agency of the prescription team established by the CSB. The team, under the direction of the CSB, shall be responsible for integrating the community services necessary to accomplish effective prescreening and predischarge planning for clients referred to the CSB (*Code of Virginia*, § 37.1-197.1).

8.3 Placement in a State Facility Operated by DMHMRSAS

Local social services departments shall refer individuals to the local DMHMRSAS CSB for preadmission screening for entrance into state psychiatric and mental retardation facilities. When admission to a state facility operated by DMHMRSAS is being sought, local social services departments may be requested to assist in preparing that portion of a comprehensive evaluation in which it has knowledge concerning an adult.

8.4 Convalescent Leave and Discharge Planning

When an adult returns to the community from a state facility operated by DMHMRSAS, a local department may be requested to participate in the facility's pre-discharge planning process (*Code of Virginia*, § 37.1-98). Adults released on convalescent status or expected to be discharged from state DMHMRSAS facilities who will be in need of social services are the responsibility of the local social services department of:

1) First, the county or city where the adult was a resident at the time of admission; or

2) Second, the locality where the adult has chosen to reside, if the locality where the adult previously resided has not maintained service responsibility for the case; or

3) Third, in the absence of such a place, the jurisdiction of the institution from which the adult is being released.

9. LONG-TERM CARE COORDINATING COMMITTEES

The *Code of Virginia* requires the establishment of a local long-term care committee in each city or county or combination thereof. The local department of social services is a member of the committee. The purpose of the committee is to guide the coordination and administration of public long-term care services in the locality.

The governing body of each county or city, or combination thereof, shall designate a lead agency and member agencies to accomplish the coordination of local long-term care services. The agencies shall establish a long-term care coordination committee composed of, but not limited to, representatives of each agency. The coordination committee shall guide the coordination and administration of public long-term care services in the locality. The membership of the coordination committee shall be comprised of, but not limited to, representatives of the local department of public health, the local department of social services, the community services board or community mental health clinic, the area agency on aging, and the local NHPAS team. A plan shall be implemented that ensures the cost-effective utilization of all funds available for long-term care services in the locality. Localities are encouraged to provide services within each category of service in the continuum and to allow one person to deliver multiple services, when possible (*Code of Virginia*, §§ 63.2-1602 and 2.2-708).

Appendix A
Adult Foster Care Agreement

I, _____, agree to pay _____,
(Name of Adult) *(Name of Adult Foster Care Provider)*

_____,
(Address of Adult Foster Care Provider, including city, state, and Zip Code)

for my daily room, board, supervision, and special service(s) as specified below at the monthly rate of $_____. I understand that I am to receive from the provider the following special service(s):

I further understand that if I choose to move, or the adult foster care provider wants me to move, a two-week notice in writing will be necessary. The two-week notice in writing must be given to _____ and to the _____
(Name of adult foster care provider) (*Local department of social services)*

I understand I may retain the balance of my income, my personal income plus my Auxiliary Grant, that remains after the above amount is paid to the Adult Foster Care Provider.

I, _____ agree to provide to the above-named adult daily room,
(Name of adult foster care provider)

board, and supervision in consideration for a monthly fee of $_____. I agree to comply with all requirements of the Department in the provision of adult foster care services.

I further understand that if the above-named adult desires to move, or if I determine that he or she shall move, a two-week notice in writing will be necessary. The two-week notice in writing must be given to _____ and to the _____
(Name of adult) *(Local department of social services)*

_____ _____
Date *Signature of Adult/Guardian*

_____ _____
Date *Signature of Adult Foster Care Provider*

_____ _____
Date *Signature of Social Worker*

Date of Entry into Adult Foster Care Home _____

cc: Adult in Care, Adult Foster Care Provider, and Local Department of Social Services

Appendix B
Adult Foster Care Interagency Agreement

_____ agrees to authorize
(Name of receiving local dept. of social services)

_____ to recruit, approve, and
(Name of placing local dept. of social services)

place adults in the Adult Foster Care Program in _____.
(Name of Political Jurisdiction)

_____ will retain the following
(Name of placing local dept. of social services)

responsibilities in accordance with Adult Foster Care policy and procedures:

1) Approval and renewal of the adult foster care home;

2) Direct services and ongoing supervision of the adult;

3) The Auxiliary Grant payment in Adult Foster Care; and

4) Arranging of services needed by the adult from other community services agencies prior to the placement of the adult foster care home in _____.
(Name of Receiving Jurisdiction)

_____ _____
Date *Signature and Title of Authorized Staff of Receiving Local Department of Social Services*

_____ _____
Date *Signature and Title of Authorized Staff of Placing Local Department of Social Services*

cc: Family Services Specialist